TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gilbert Mayorga, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-2875-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In brief, we were not paid according to the fee guidelines for 99456 W5 WP 3 units. Three body areas were impaired to include shoulder, facial fractures (orbital fracture and nasal fracture) and visual system (diplopia). We were paid for 2 body areas… Furthermore the original narrative report had a transcription error and omitted the majority of the visual impairment narrative that was sent to all parties on June 5, 2016. The error was noted the next day and a [sic] amended report was prepared and sent to all parties."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed 3 units of 99456-W5. Review of the narrative report shows the requestor assessed the shoulder, orbital fractures, and nasal fracture. Texas Mutual paid $300.00 for the shoulder assessment and $150.00 for the orbital fracture/nasal fracture consistent with (j)(4)(D)(i)(II)…"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 29, 2015	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-18 – Exact duplicate claim/service
   - 224 – Duplicate charge.
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to Texas Medical Fee Guideline.

Issues

1. Did the requestor support the units billed for the disputed services?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking an additional reimbursement of $150.00 for procedure code 99456-W5-WP, billed at 3 units, for a total reimbursement of $950.00. The insurance carrier paid $800.00, stating that the reimbursement was for 2 units. The insurance carrier stated in their position statement that "the narrative report shows the requestor assessed the shoulder, orbital fractures, and nasal fracture."

   The requestor asserts that he is eligible for 3 units which include the shoulder, facial fractures, and vision system. The requestor cites a transcription error which left out much of the reference to the impairment rating for vision, but states that "The error was noted the next day and a [sic] amended report was prepared and sent to all parties." Submitted documentation finds a narrative for the date of service which includes the left shoulder, vision, and facial fractures of nose and orbit. Further, submitted documentation also includes a narrative with the notation "Amended 5/30/2015" which includes a more in-depth discussion of the impairment for vision. Documentation supports that the requestor submitted this report with billing to the insurance carrier, where it was denied as a duplicate billing.

   The division finds that the requestor supported the units billed for the disputed services and is subject to reimbursement in accordance with the appropriate fee guidelines.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

   > (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   > (i) Musculoskeletal body areas are defined as follows:
   > (I) spine and pelvis;
   > (II) upper extremities and hands; and,
   > (III) lower extremities (including feet).
   > (ii) The MAR for musculoskeletal body areas shall be as follows…
   > (II) If full physical evaluation, with range of motion, is performed:
   > (-a-) $300 for the first musculoskeletal body area; and
   > (-b-) $150 for each additional musculoskeletal body area.
   > (D) …
   > (i) Non-musculoskeletal body areas are defined as follows:
   > (I) body systems;
   > (II) body structures (including skin); and,
   > (III) mental and behavioral disorders…
   > (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the left shoulder, the vision system, and facial fractures. Documentation supports that the requestor

performed a full physical evaluation with range of motion for the left shoulder. Therefore, the correct MAR for this examination is $600.00.

3. The total MAR for the disputed services is $950.00. The insurance carrier paid $800.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.